MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Thursday, December 12, 2002
9:44 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA D. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Assessing payment adequacy and updating Medicare payments

DR. SOKOLOVSKY: Good afternoon. Today, to help the Commission consider its recommendations for an update for physician payments we would like to summarize the evidence on the adequacy of the current payments. We will then account for expected cost changes in the coming year, present our draft recommendations for your consideration, and address the budget implications of our recommendations.

In 2001, total payments for physician services, that includes both program spending and beneficiary cost sharing, equaled about $56 billion, about 25 percent of total Medicare spending. Payments have been increasing at an average annual rate of 4.9 percent since 1991.

Recommending a payment update for 2004 is complicated by the uncertainty of the update for 2003. Current law, as you all know, requires an update of minus 4.4 percent. In legislation passed by the House this summer, the reduction would have been replaced by a positive update of 2 percent. Congress could take up this issue again when it returns in January although we cannot predict what actions they might take. Kevin will speak more about this issue later.

As in our other update discussions we wanted to give you an estimate of projected expenditure growth. This slide displays the updates in payment rates required under current law from 2001 to 2006, as well as program expenditures for physician services as projected by the Office of the Actuary for this same time period.

On the right axis I want to note, one equals the 2001 rate and the updates for the following years are expressed as ratios of the 2001 rates. The left axis equals program spending as projected by the Office of the Actuary, which was about 2 percent. Note that OAC projects a slower rate of expenditure growth than does CBO for the same period. As you can see despite the series of negative updates called for under current law, both the Office of the Actuary and CBO 50 -- -- and CBO have projected program spending to grow at an annual rate between 2 and 4 percent.

As we notes in the mailing materials, the available

information presents a mixed picture of payment adequacy. The number of physicians billing Medicare has more than kept pace with growth in the number of beneficiaries. From 1995 to 2001, the number of physicians grew by 8.1 percent, while Medicare Part B enrollment grew by 5.7 percent. The differences in growth rates led to an increase in the number of physicians per 1,000 beneficiaries from 12.9 to 13.2.

Secondly, our MedPAC 2002 physician survey found that 96 percent of physicians who were accepting some new patients were accepting at least some new Medicare beneficiaries. This was a higher proportion than those physicians accepting new HMO or Medicaid patients.

However, the percentage of physicians accepting all new Medicare fee-for-service patients fell from 76 percent in 1999 to 70 percent in 2002. I want to add that these results are consistent with the findings from the Health Systems Change survey but our results are more recent since our survey was 2002.

Although many physicians reported changes in their practices, the relationship between those changes and Medicare payment policy is unclear. Two-thirds of physicians said that they delayed or reduced capital expenditures. On the other hand, more than a third of physicians reported that they had increased the number of non-physician clinical staff and more than half increased billing and administrative staff. Three-quarters reported that they had increased their patient load in an effort to increase revenue.

Thirdly, as you've just hear, Medicare payment rates as a percentage of private payer rates increased from the late '90s through 2001. The 2002 payment rate reduction reversed this trend, but Medicare rates as a percentage of private payer rates remained at a higher rate than in the 1990s.

Lastly, last month we presented evidence on growth in the volume of physician services from 1999 to 2001. Overall volume growth was 2.7 percent, a rate consistent with the trends in the 1990s following implementation of the physician fee schedule. By January we hope to be able to present 2002 data on growth in volume for specific services.

However, it should be emphasized, as we discussed last month, that much more analysis is required to understand the factors underlying volume growth and we're not going to be prepared to do that until the June report.

Nevertheless, the trend in volume increases, the data on entry and exit of providers, and the results of the studies presented to you earlier support the argument that the level of payments for physician services was at least adequate in 2001.

DR. HAYES: So Joan has covered what we know about the first element of our payment update framework, which is payment adequacy. I'd like to talk now about the second element, which is changes in costs that we anticipate for the year 2004.

Two factors are important here. First is input price inflation, and second is productivity growth. The preliminary information we have on input price inflation from CMS is that for 2004 they're projecting an increase in input prices of 3.4 percent. That's the total. Within that, the two major

categories that are considered are physician work and practice expense. Physician work expected to go up by 3.4 percent. That's weighted. It's roughly 55 percent of the price increase. And practice expense going up at a similar rate of 3.3 percent and weighted at the other 45 percent.

The practice expense component of this input price inflation is a broad category that includes a number of things like compensation for non-physician staff working in the office, rent, and so on. One of the categories of practice expense is professional liability insurance. This is, of course, the insurance coverage that physicians have to protect them in the even of a malpractice suit. That component of practice expense has the highest projected increase at 4.4 percent. It's worth noting, however, that that component has a pretty low weight, roughly equal to about 3 percent of physician revenues.

The other factor that we consider here is productivity growth. Our analysis of trends in multi-factor productivity suggests that the trend is an increase in productivity growth of 0.9 percent. We'll put these two numbers together, the input price inflation and productivity growth numbers in just a moment.

So that brings us then to a draft recommendation for your consideration that would appear in next year's report but would be for the year 2004.

Before we get to that question let me just say a few things about the status of the update for 2003. As Joan indicated, the current law update for 2003 is minus 4.4 percent. There's pretty widespread agreement in the health policy community that such an update would be a problem. Unfortunately, there is no solution in place just yet. But as far as I know, the Commissions's position on this matter remains that a modest positive update would be appropriate for 2003.

So if we take that as our starting point than our task ahead is to try and come up with an update recommendation for 2004. An option for Commission to consider here, of course, is to adopt a recommendation like the one that was in our March 2002 report, and that would be the one that you see here, which is an update based on the projected change in input prices less an adjustment for productivity growth. Drawing on the numbers that were on the previous slide, that would lead us to that update recommendation, based on the preliminary information that we have now, of 2.5 percent for 2004.

We should talk then about the budget implications of such a recommendation. Here we need to contrast this recommendation with current law, and for 2004 that is another decrease, this time of 5.1 percent. The resulting difference then between our recommendation and current law would put us in the category of a budget implication that would be greater than $1.5 billion dollars. I should point out though that there's a possibility that the budget impact would be less than that if, for example, there is some action like that that was in the House bill that was passed this summer which would have legislated a payment update and made other changes in the update formula for physician services that would have prevented these reductions.

The other possibility here is that there will be some action

to correct errors in the current payment update formula. That too would prevent payment reductions.

Thinking further about these budget implications and what the five-year impact of our recommendation would be, we have a dilemma there. The problem is first that under current law any increase of the type that would be recommended here would be taken away through the update formula that's in current law. Such an increase would be taken away in a subsequent year.

The other problem in making a longer-term projection is that it puts us in a position of having to make some -- use some rather controversial assumptions about behavioral offsets, about physician actions to offset payment reductions by increasing the volume of services.

Then the third thing, of course, is this possibility that there could be some action to change the payment update formula and prevent the payment reductions. So for that reason we don't feel that it's prudent to report a five-year budget implications for this recommendation.

That's it.

MR. HACKBARTH: Let me make something explicit that's been implicit in what Kevin presented. Last year you'll recall our recommendation had two parts basically. One was too repeal the SGR mechanism and then the second was to replace it with annual update that was based on the MEI minus a productivity factor.

Here we're talking about in the first instance the MedPAC recommendation for 2004, but we all have the dangling question of what happens with the scheduled cut for 2003? So what I would propose and I'm eager to get your reactions to it, is that our approach be that we not go back to the SGR issue. We've made our views clear on that. Haven't been well-received in all quarters. I don't see any gain in going back to that issue.

What I would like us to address is what we think is the appropriate increase for 2004, and a statement about what we would have liked to have seen happen in 2003. Hence, there would be a recommendation that says -- I think the words that Kevin used in the paper were, MEI minus productivity for 2004. In the text we would say, in addition, we believe there should have been a modest increase in fees also for 2003. Again, no explicit reference to our SGR position.

So I'd solicit comments on that.

DR. NELSON: Just a clarification, Glenn. We would certainly not disavow our earlier recommendation with respect to the SGR.

MR. HACKBARTH: We would not.

DR. NELSON: We just wouldn't lay it out there front and center.

DR. REISCHAUER: But I think we would have to say that our 2004 recommendation is premised on the assumption that the 2003 recommendation, or something in that ballpark, is adopted.

MR. HACKBARTH: That's correct.

MS. BURKE: To that point, I just want to understand the implications of this. If in fact we come to January, the expectation at the moment is that the Labor bill, along with the other remaining bills, is going to be the first business at hand,

which potentially could be the first week of the 7th. If in fact there is an attempt on the part of either the House or the Senate to go back and try and fix some of these things, I assume that part of what will happen here would ultimately be adjusting for what ultimately would occur, in anticipation of the March report.

To Bob's point, if this assumption is based on current law as a base or on the expectation that there'll be an adjustment to '03 -- I mean, if you assume that you're proposing for '04 an increase that simply reflects the inputs now but doesn't correct the base, so it understates what in fact we think ought to occur, correct? Am I reading that correctly?

MR. HACKBARTH: Correct.

MS. BURKE: So that the statement would be that this adjustment presumes -- in order to be adequate under our test of what is adequate, presumes that there has been adjustment to the base that raises the base to a reasonable level and it is the adjustment to the base. In the absence of that, this is not an adequate adjustment.

MR. HACKBARTH: Exactly.

MS. BURKE: In some fashion that has to be described without getting in their face.

MR. HACKBARTH: Exactly. That's the challenge.

MR. SMITH: I would think though we'd want to say it using the words that we use in the framework. That we want to be explicit. That payments are not currently adequate unless. Therefore, we would have to take a two-step process in the 2004 update. We'd have to address the underlying inadequacy and then the update of MEI minus productivity. So we'd have a two-part recommendation. Because we probably won't know, even if they take up the appropriation bills early, we're unlikely to know when we meet in January.

MR. HACKBARTH: I think that's true. It's unlikely that this will have been resolved.

DR. ROWE: Just a question on the data. As a member of the AMA I get a lot of material from the organization that talks about malpractice and the rates and how this is really one of the major concerns the AMA has currently. In addition, in my company we hear an awful lot, not only from the AMA but also from physicians around the country about malpractice rates and how the increases there require increases in the rates that we pay physicians for them to -- so that they can stay even, if you will.

I'm not surprised to see that malpractice or liability insurance is the most rapidly rising, but I am very surprised to see that it's only 3.2 percent of the expenditures, because even if it's rising at 4.4 percent per year, if it's only 3.2 percent of the expenditures why is there such a terrible furor about this? Are we sure about this number, that it's such a small portion of physicians' expenses?

DR. HAYES: That's the number that we have. It's based on a survey that the AMA conducted some years ago on spending for different inputs as a share of total revenues received. That percentage has moved around a bit over the years but it's always been, my recollection is that's always been under 5 percent

anyway.

DR. REISCHAUER: It varies tremendously by type of practice.

DR. HAYES: Yes, it certainly does.

MR. HACKBARTH: Kevin, you said it's based originally on a survey that was done some years ago. Is the fact that it was done some years ago potentially an issue and a reason why this number may be off the mark?

DR. HAYES: It could be. The MEI, as the actuaries say, it is rebased periodically. The current MEI is based on 1996 weights. We can find out from CMS when they plan to rebase the MEI. It is possible to rebase it, I would think with newer information. There is a newer survey available.

DR. ROWE: I may be the only one that thinks it's off.

DR. NELSON: No, you're absolutely right.

MS. BURKE: But also to Bob's point, there are huge variations based on geography and practice, types of practice, the Ob/Gyns versus the anesthesiologists, versus the interns. At some point we ought --

DR. NELSON: They're all up this year, Sheila.

MS. BURKE: I'm assuming they're all up. But not only are they all up, but there are enormous variances. So that a statement of it's three or five or four, grossly understates some of the huge variance.

MR. HACKBARTH: I have no clue what the right number is. Like Jack, I guess I'm surprised to hear it's that small. Although if it's even close to that number, even large increases would not be having huge effects.

DR. ROWE: Why am I getting beat up about 4 percent increases?

MR. HACKBARTH: So even if it's perfect, and presumably it isn't perfect -- nothing that we do it, but even if it's 10 percent, it's not going to be the problem that the rhetoric would lead you to believe. There's a disconnect here between the passion and the numbers that we see.

MR. FEEZOR: Glenn, I' think take part of that is both the suddenness and the fact that there are no answers to go to when you have a major withdrawal from the market, so it's a real -- that's the reason there's a lot of passion on it.

DR. NELSON: And it comes out of your take-home. It isn't something you can pass along any more. You can't just raise your fees because your liability rates go up $50,000 a year. You eat it.

DR. ROWE: If it's 4 percent of 3 percent, it's a cup of coffee.

DR. NELSON: I'm talking about what premiums are going up.

DR. REISCHAUER: But the 4 percent is a projected increase for 2004 after we've had huge increases in 2002 and 2003. That's what they're howling about. So what this is saying to you, Jack, is just hang out, 2004 it will all die down.

DR. ROWE: I guess the question, and I think I've gotten the answer which is kind of a new experience here.

[Laughter.].

DR. ROWE: I was thinking that even after all these huge and unprecedented increases -- and I'll be happy to wave the flag for

tort reform. I'm on that side of the table, as you might imagine. I thought that even after those increases we were at 3.2 percent. It sounds like we were at 3.2 percent sometime in the past before all these increases. So we may be at a higher number, but still it's not going to be 20 percent.

DR. STOWERS: In the original formula, the PLI is not put in the other practice expense. We've kind of thrown that in here, and I'm wondering if it wouldn't be good if we went back to the original three parts of the formula and tracked it that way so that we can see what this PLI thing is doing, Kevin. Because the formula is actually broken down into physician work, practice expense, and PLI as the three parts, and it might be confusing people here to have that PLI factor thrown into the middle of the 3.2 that's the other practice expense.

DR. NELSON: It needs to be in both because it's establishing relativity.

DR. STOWERS: That's what I mean. But when we thrown it in the rest of all of the other practice expense it gets swallowed up in the numbers there.

DR. MILLER: Can I just make one point on this? Kevin, when we discussed this I also thought that there was some sense of a cycle here, an underwriting cycle that occurs. So in a sense, depending on how much inside the index you get, you're going to always be chasing, up and down, depending on where the underwriting cycle is.

DR. ROWE: I think, Mark, there are two cycles. We can turn this into a PLI discussion. I had the misfortune of, when I was running hospitals, having an offshore medical liability company. I'm sure Ralph had one too. One piece is the underwriting cycle. The other piece is the reduction in the value, and therefore the income from the assets that were underlying a lot of this, the reserves. So the stock market goes down, so that the premiums go up. I think that some people think that that's one of the very significant drivers recently, in addition to the size of awards and all the rest of it. But that's one of the more recent important -- so it's not just the cycle. You can see how that would have a direct impact.

MS. ROSENBLATT: I have a strange comment to make and please don't throw me out of the room. I know our charge is to come up with an overall update, given the framework that we went through earlier today. But hearing the number that was just mentioned by Kevin got me very concerned. It's a big number.

MR. HACKBARTH: You mean the expenditure number of --

MS. ROSENBLATT: The budget implication. Is there any way for us to, instead of doing a general update for all types of physicians, is there any way instead to do -- when we were talking about the transition that carriers went through due to RBRVS where carriers didn't want to decrease specialists' rates and needed to increase the E&M rates, is there some in-between type of recommendation that looks at a finer level of detail? That's my question.

DR. NEWHOUSE: I can't resist putting in a couple, comments about the PLI. My recollection is I've never seen a number over 5 percent going back well into the '80s for the share of total

practice expense. I think Bob's point is exactly right, that there were much bigger increases in 2001, 2002 although it's still -- you multiply it by a small share; it's not that big an increase. I would have said the passion you're seeing, this is not exactly a newfound passion and a lot of the passion reflects the fact that many of the costs are not insurable. They're costs to your reputation, there's cost of your time to defend the suit. It's not the world's most pleasant experience being on the stand and I'm not surprised by that.

I think this discussion has appropriately focused on how do we frame what we're going to do in 2004 given what happened in 2003? But I wanted to raise another point that points also in a somewhat dovish direction to me. That is, I think we got -- in our normal update framework we want to try to account, however imperfectly, and it's pretty imperfectly, for productivity and technological change. Productivity comes in here as economy-wide productivity. That's a first order approximation, but it is an approximation. There is no reason that the physician sector should be exactly equal to economy-wide productivity. If you had to bet, at least I would probably bet that large parts of it were less, but some parts of it may be more.

Be that as it may, my main comment was I thought this got rid of the technological change factor too readily. That is, I'm mindful of a remark Jack made, several years ago now, where he talked about the fact that -- this was in a somewhat different context, but that the 85-year-old person who you were trying to get onto the x-ray table took more time than the 67-year-old typically took.

You've noted -- this is a very helpful chart about what was increasing and what was not increasing so much by procedure type, and your remark there was that these were old technologies that were showing the big increases. My question was, so why were they showing the big increases?

My guess is they were showing big increases because as you send, actually the indications for them were changing, but I think the indications were changing because we were willing to do these things or the things they were going to lead to, on clinically riskier patients, meaning to a first approximation, the older-old. Those are precisely the people that may take more time. So I'm not quite so willing to get rid of technological change as not increasing costs here.

Now how much is it worth? I don't know. I don't know how we would ever figure it out but it would lead me to tilt toward being somewhat more generous, or at least not doing a slavish adherence to an MEI minus economy-wide multifactor productivity.

DR. HAYES: If I may, one an option for us here is to pursue the project that we have in mind for the June report, which is to talk about volume growth in more detail and to look more closely at just this very question of whether the changes and indications for use of procedures are leading to different types of patients getting these technologies. So, yes, putting the number on it would be difficult to do, but if we do that further work we might get a little bit closer any way.

MR. HACKBARTH: Joe, to the extent that -- I think the

initial thinking of why we didn't need a separate adjustment was that we've got very small bundles here. So as practices change, new technology is introduced and people use more complex services, it flows automatically through the fees that we pay.

I understand your point, but that still seems like a pretty good baseline assumption that we're getting the vast majority of the technology change just through the fee schedule payments. Yes, some of these may take a little bit more time to deal with an older person for a particular procedure but we're getting --

DR. REISCHAUER: But isn't that picked up in the reweighting every couple of years? So that wouldn't make a difference, I don't think. I mean, there's a lag but when I look at this, the things that have increased most rapidly are all imaging of one sort or another. I don't know, but I'd be surprised if the age distribution of imaging has changed radically over the last five years of who is imaged.

DR. NEWHOUSE: I guess we'll find out in June.

DR. REISCHAUER: I can wait.

DR. NEWHOUSE: I'm willing to make a side bet, by the way.

DR. REISCHAUER: You're on. Let the audience be the witness.

[Laughter.]

MR. HACKBARTH: Let me just ask one other question about Joe's productivity comment. We have this placeholder, if you will, of 0.9 -- we have this uniform productivity factor of 0.9, and you're saying that you think for this particular segment that it might be a significant overstatement?

DR. NEWHOUSE: No, I don't know how significant it is. I don't think we're ever going to know that. In my gut, 0.9 a year sounds a bit high, certainly for the E&M-based docs. Maybe the radiologists and the pathologists can make it. I don't know.

MR. HACKBARTH: Let me be real direct. We're at a point where we're getting very near to where we have to make recommendations, and even if things aren't quite right theoretically, this isn't a right number, I think what we have to do is disciplined ourselves to say, do we have really a compelling reason why we'd want to move this number for this segment? That's what I'm trying to push you for. It's almost certainly not exactly right, but I respect your judgment a lot, Joe, on whether you think it's likely to be so far off the mark that we ought to do something different.

DR. NEWHOUSE: No, the most I was thinking of was a few tenths of a percentage point and maybe the game isn't worth the candle for the combined effect of productivity and technological change. But I thought maybe just the text, if we're going to do this, would carry a discussion of this could be off in either direction and some reasons why it might be.

By the way, the fact that these are old procedures -- to go back to the point -- actually makes I think where I'm coming from stronger. If there was a new procedure then I would think that costs might actually be falling in ways that this update factor wouldn't pick up right away. But I think the unit costs here for a given patient are probably pretty stable at this point.

DR. REISCHAUER: My guess is when you get into imaging

you're getting economies of scale because you're running these machines 20 hours a day.

DR. NEWHOUSE: Yes, but some of them turn out to have fairly substantial marginal costs.

MR. DURENBERGER: Thank you, Mr. Chairman. First observation I have is that there's no way on God's green earth how I could argue with 2.4 or anything else and if at the end of March, like the rest of you I'm defending a number, I'm more likely to defend the process that we've gone through than I am to defend a specific number.

I guess the second part of that is, I have been instinct that tells me, regardless of what we say this year there are other forces at work that are probably going to determine what that number and related numbers are likely to be.

But the third point is, for me personally as a member of this commission and as someone who represents MedPAC in that context after the numbers come out and so forth, it's what we say about what's going on in the practice of medicine I think is much more important, and that might be pointing to June or something like that.

There isn't a person on the Hill that when 2.4 percent comes out isn't going to hear from one of the 200 professional societies that are affected by this, and they'll tell them, this isn't adequate.

So there's nothing we can do here that's going to please anybody, but we might be able to tell somebody who's paying these bills and designing the structure for paying these bills, that there are things that we can observe as in the studies that preceded this testimony and what we hear here, there are things that we can observe now that will suggest to us -- and this is partly I think Alice's point -- suggest to us that there are some modifications in the way in which Part B reimbursement should take place that might reflect certain of the ways in which, particularly on the subspecialty side, medicine is being practiced today in America.

The imaging part of it is probably the one that anecdotally will bother me the most because in November had I been wise. in this great group practice state of Minnesota with its lower costs and everything, I could have had a full body scan for only $300 had I wanted one.

DR. ROWE: It's not worth it.

MR. DURENBERGER: I know it isn't worth it. I know it's not worth it, but a whole lot of people don't know it's not worth it, which gets to the issue of, how can we begin to speak to the issues of appropriateness, and intensity, and some of those related issues that other people around here and people we know are talking about all of the time? That are some indication to the folks that have to take responsibility for paying those bills or raising the money, that there's something different --

MR. HACKBARTH: I agree, Dave. What we heard or what I heard was, frequently, about our SGR recommendation was that we were giving short shrift to an important problem for the Medicare program and for the budget; namely, the potential for growth in the volume and intensity of services. So we were going back to

an old world, or proposing that Medicare go back to an old world where we just pay for each unit of service, pay no attention to volume and intensity. The critics of our position said we can't afford that.

So I do believe that that, even if it's not a pressing issue as we speak, the volume and intensity is not growing rapidly by historical standards right now, it is a long term issue for the Medicare program. So I would like to pursue further the work that Kevin and others have begun, looking at where the volume increases are. Exactly where it leads, I'm not sure, in terms of policy prescriptions. But hopefully, if nothing else, we should be able to shed some light on the nature of the volume and intensity issue. But that is for June and perhaps beyond June as well.

DR. STOWERS: I won't take too long on this but I'm getting back to on assessing payment adequacy. We also have at the top of the list entry and exit of providers and we take that as some solid indicator of where we are. I wonder, Kevin, if this wouldn't be a place where we could go a little deeper into that, because I think it's a very, very lagging indicator. To me, you've got those people that are not dependent on Medicare and what we're seeing is they're tending to stay in the program, so they're not one of those numbers that are going down as Medicare. They've got other sources of income. They can accommodate families and referrals and they stay in.

Then we've got those categories that are dependent but some of them have an option to do something else, so they can nix -- maybe in a more urban area they can switch the ratio of their practice, or they can go to new modalities, or they could discontinued altogether, but most of them don't. Then you've got those that have no options and we're already seeing difficulties with some of the physicians that know they're going into very Medicare-dependent practices, rural, innercity, whatever, that are just flat either leaving because they're fearing that point of not being able to make it or that we're having trouble recruiting them there in the first place.

So I think dependence on the practice and those options that they either have or do not have, but almost in all of these categories the enrollment numbers are pretty well going to stay the same, whether they move their practice and leave underserved left out there.

So I think we put so much weight on that entry and exit that that bothers me a little bit. So I think we need to qualify that and just being right up front that, the survey says it went down 5 percent. I think when it goes down 5 percent or 10 percent, that's a lot bigger message being sent to us than just what the number would indicate. I think we have a chance here to explain that a little bit.

So I agree with your recommendation in your paper and all of that, but I worry about the weight that the general public out there might put on just rawly looking at those entry and exit numbers because they're way understated. Somewhere I think MedPAC ought to step up and say that.

DR. HAYES: Can I just ask a clarifying question? When you

said the 5 percent drop you're referring to --

DR. STOWERS: I don't remember the exact number. In our survey that we did. I think that we all agreed that was a significant number, even if that raw number just meant that. But I think it means a lot more than that, and could mean more in different situations of Medicare-dependent practices, geographic distribution. When we look at access to care I think we have to look overall, but we also have to look to specific geographic areas that may be affecting more than others. I just think we could get into that a little bit deeper, especially if we're going to keep it number one on the list, which every list that comes out has entry and exit as the number one thing.

DR. NELSON: My comments on PLI and productivity factor have been made thanks to others. I won't make those again.

But I would like to put on the record my concerns about the need to watch closely the participation rates and have a sentence or two about that, because I believe that with the cuts in payment a lot of physicians will examine their practice and make a decision about whether or not to no longer be participating physicians so that they can bill up to the limiting charge. That that will be an option that some may very well take advantage of.

Now what obviously that does is transfer that burden to the beneficiary, and that's a concern for me. But I believe that physicians in areas where there are waiting lists of Medicare patients and waits to get in to see them, may very well decide that in order to keep their practice going the way they want, that they have do that. So it will be very important to watch participation.

MR. HACKBARTH: Yes, so the participation rate could be a leading indicator of, a more sensitive indicator than even access, as we're measuring it in the survey. So I think it's worth watching.

Based on the work that Chris did I want to pose a question, probably and unanswerable one, but what we have as described by Chris is a changing pattern on the relationship between Medicare fees and private fees. A significantly larger gap in the mid-'90s than exists today. Although recently we saw the gap between Medicare and private fees go down to less than 20 percent, and now with the 2002 cut it's begun to widen again, and certainly would widen some more if there's a 2003 cut.

The question, of course, that all that begs is, what does that mean for access? Does that mean if the 2003 cut goes into effect that there's going to be a direct effect on access? We can't answer that question, but I would hope maybe we can at least put the numbers in context.

As I read the results, basically after the 2002 cut, the relationship between Medicare fees and private fees is about where it was in the late 1990s, at which time all of our surveys of access showed that there was good access. In fact we made explicit conclusions that access to care was adequate. So I think that's one specific point worth mentioning to our audience.

That, of course, begs the question, is there any reason to believe that on the way down that there would be a different response by physicians than there was in the 1990s? So it's the

same ratio of Medicare fees to private fees but will they respond differently this time than they did before?

DR. REISCHAUER: I think it depends on the external environment and the extent to which there are other potential patients out there to fill up their excess supply. As the baby boom ages, one would expect the answer to that would be yes, because there's many people under the age of 65 who are increasingly high utilizers, for whom if they can control utilization or influence utilization, they might have a substitute, which was less true -- it is a very gradual kind of demographic shift. So I would expect the impact to greater at an equal level of relative payments than it was before, unless they're losing their insurance. We have slightly higher insurance rates now than we did back then.

MR. HACKBARTH: By think the question that the data beg, and it's the question that the policymakers will want to know, so to the extent that we can shed even a little light on it I think that would be useful.

DR. STOWERS: There was a chart that we used on the hospital payments, or the Commission did a couple of years ago or whatever, that had the economic index and then it had what Medicare was paying and then imposed on that what the private payment was. I'm wondering if we couldn't translate that from the hospital world and do one of those on physicians, because it then would show when private pay was coming down. It would be taking part of what Chris told us today and part of what you're telling us and putting that together.

DR. NEWHOUSE: But the constancy of those -- in the numbers that Christ showed suggests there wasn't the big swing that there was on the hospital side.

DR. STOWERS: But there was a time when private was going down also. That's what really affects --

DR. NEWHOUSE: But those numbers didn't bounce around very much, Ray. They didn't bounce around anywhere near as much as the hospital numbers went around.

DR. STOWERS: It just would be interesting to see.

MR. HACKBARTH: I think that's it for now on physician payments.

Next up is outpatient dialysis. Okay, Nancy.

MS. RAY: Good afternoon. Switching topics, I will be discussing the adequacy of current dialysis payments and updating the composite rate payment for calendar year 2004.

Two questions that you should keep in mind during my presentation. One, do we believe that Medicare's current payments for all services provided by outpatient dialysis facilities are at least adequate? And two, what would be needed to account for anticipated increases in efficient providers' cost in 2004?

Just to briefly review their revenue streams that facilities are paid for furnishing provider Medicare services. They're primarily two. The composite rate payment cover the outpatient dialysis session and this prospective payment system was

implemented in 1983 and covers many of the services associated with the treatment including nursing supplies, equipment, and specific labs and drugs. On average, facilities receive about $130 per treatment and facilities are paid for furnishing up to three hemodialysis sessions per week. The other major stream of revenues that facilities are paid are for injectable drugs. Notably, the composite rate bundle does not include certain drugs that were not available in 1983. These drugs include erythropoietin to treat anemia, IV iron, and vitamin D analogs, to name a few.

What does Medicare pay for these drugs? For Epo, Congress sets the payment rate, and that is $10 per 1,000 units. All other separately billable drugs are 95 percent of AWP.

To review the services provided by freestanding dialysis facilities in 2001. In 2001, there were about 3,300 facilities and they treated roughly 220,000 beneficiaries. Estimated spending for dialysis services is about $3.3 billion and for injectable drugs was about $2.3 billion. CBO projects spending for outpatient dialysis services, and that includes the separately billable drugs, to grow at about 9 percent per year between 2004 to 2008.

At this point I'd like to again switch gears a little bit and go into our two-step model that assesses payment adequacy and updates payments. The first step in our model assesses payment adequacy. The way we do that is to estimate current -- that is 2003 -- payments. We compare that to providers' cost. We do that to evaluate whether current base payments are either too high or too low.

For the dialysis sector, we will do that using 2001 cost report data, which I just got at the end of November. Now before I start getting into those numbers, the 2001 payment to cost ratios and the 2003 projection I'd just like to take a step back at this point.

MedPAC's analysis of payments to cost is based on Medicare allowable costs. I raised this issue in the March 2002 report and I think staff has gone a little bit further in our analysis of the effect of CMS's audits of dialysis facilities' cost reports. think it's important for the commissioners to consider the effect on -- to consider the relationship of current payments and costs when the costs are based on Medicare allowables.

The 2001 cost reports have not been audited. If history is any guide, a portion of the reported cost included will most likely be found to be non-allowable, when and if they are audited. The most recent year that we have audited data is 1996. Preliminary results of the audited 1996 cost reports show that allowable costs per treatment for composite rate services for freestanding facilities average about 95 percent of the reported treatment costs. So this would increase our composite rate payment to cost ration by about five percentage points, as well as our all service payment to cost ratio that includes both composite rate services and separately billable drugs.

Just to let you know that an older audit that was done back in 1998 found, for dialysis facilities, that allowable costs for treatment for facilities averaged about 88 percent of their

reported costs for treatment. So our findings are not terribly unexpected.

The biggest reduction in the cost per treatment that we have found were for administrative costs. Those were reduced by about 70 percent. The other costs were roughly in the 90 percent level for labor, capital, and other direct costs.

Now this graph displays a historical comparison of Medicare's payments to providers' cost. Again, these data have not been audited. The 2001 data point is not up there yet because I was still working on it. I'd like to caution commissioners that the 2001 data point is preliminary at this point and we are going back and triple-checking all of our data.

Our preliminary analysis on the all-service payment to cost ratio is that it is about 1.01, and that the composite rate payment to cost ratio is about 0.93. That's for 2001. That's not on this graph.

DR. ROWE: Am I getting this right, that's a significant reduction from where it was, and the other is 0.93?

MS. RAY: Right. In 2000, the all-service payment to cost ration was about 1.05. This is unaudited.

DR. ROWE: This is not for publication. So what you're saying is that there's a kind of parallel reduction in the two of them, the composite rate services and the all-services?

MS. RAY: That's correct.

DR. ROWE: Which I don't understand based on the material here, but I'll wait till she finishes.

MS. RAY: Let me keep going. If we would correct for the audit, then the all-service payment to cost ratio and the composite rate payment to cost ratio would go up. The all-service ratio would go up to about 1.06. If we decreased costs and made them 95 percent, which is what the audit result suggests, and the composite rate payment to cost ratio would increase from 0.93 to 0.98.

MR. HACKBARTH: Say again what the combined --

MS. RAY: The combined would go from 1.01 to 1.06.

MR. HACKBARTH: for 2001.

MS. RAY: For 2001. Again, I do want to just caution --

DR. ROWE: Which means that basically if you were to put it on this curve it would just go up a little bit; is that right?

MS. RAY: No. The results up there are also not audited. so the whole line would shift. We would shift up.

I'd like to make a couple of points about this graph and about the 2001 findings. Just first off, and we've said this before, I think these findings continue to demonstrate that separately billable jobs cross-subsidizing the composite rate payment. Many have studied the fact that AWP on average significantly exceeds providers' costs. The OIG has looked at this matter specific with separately billable dialysis drugs other than Epo and also found that to be the case.

The OIG also looked at payments for erythropoietin a while back, back in 1997 and also found that those significantly -- that payments significantly exceeded providers' cost.

The next issue I'd like to discuss is the drop in the payment to cost ratio between 2000 and 2001. The drop occurred

because of a spike in the cost growth in composite rate services between 2000 and 2001. For example, the average cost of composite rate services went up between -- and again, preliminary numbers -- it went up about 5.7 percent. By comparison, between 1997 and 2001 it went up about 2.1 percent.

Now within the cost categories of the composite rate cost the two components that spiked up were labor, which is I think not terribly unexpected given from what we hear about providers and their having to compete with other health care providers like hospitals and SNFs for RNs and technicians.

The other area that spiked up was in administrative costs, the G&A category. Both of those, the 2000 to 2001 increase was much greater than the '97 to 2000 average annual increase.

The cost growth in the separately billable drugs, although it is greater than the composite rate services was generally constant between 200 to 2001 compared to the '97 to 2000 period. Whereas, the composite rate services are under a prospective payment bundle, the separately billable drugs are not. I think the reasons for the cost increase there are a little bit different. More has to do with the manufacture of erythropoietin raising the price of that drug in both 2000 and 2001, and the fact that newer drugs are increasingly being used in the later years, in 2000 and 2001.

The last point I'd like to make about this graph is that while it's the most comprehensive measure that MedPAC currently has, I'd just like for commissioners to be aware that several national chains own laboratories and they receive payments for lab testes that are furnished to dialysis patients that are outside the composite rate bundle. In addition, some facilities are beginning to furnish the diabetes educational services that are now paid for by Medicare and staff will begin to look at that and the extent to which that's being furnished.

So now to project current payments and cost for 2003. Again we used our preliminary results from the 2001 cost report data. We projected costs for 2003 by assuming costs will grow at the dialysis market basket index. We also assumed continued productivity improvements on the part of providers.

We modeled payments for 2003 to reflect current law which does not change the composite rate in 2002, 2003, or 2004. So based on current law our model suggests that the payment to cost ratio would decline by about three percentage points lower than the 2001 level.

At this point I'd like to talk a little bit about market factors that we looked at. The first one --

DR. ROWE: Could you just say that again about the net effect? It's going to decline by how much?

MS. RAY: By about three percentage points lower than the 2001 level for the all-services.

DR. ROWE: Audited all services? Is it the 1.01 or the 1.06?

MS. RAY: The projection was based on the unaudited data, but it doesn't really make a difference because you're just talking about the level.

DR. ROWE: I understand. So it's 3 percent of the 1.06 not

of the 0.98?

MS. RAY: That's correct.

MR. HACKBARTH: If we used the standard that we have used in the past which would be to look at audited costs, as we do for all providers, that's our benchmark if you will, then it would have declined from 1.06 to 1.03 is the projection for the combination of composite --

MS. RAY: That's correct.

DR. ROWE: In 2003.

MS. RAY: And current law did not update -- that takes into account no increase in the composite rate payment in 2002 or 2003.

DR. NELSON: Since 40 percent of the payments are for separately billable drugs and since the AWP is to be replaced with a fee schedule established by CMS, and since there's no way to know where they're going to set that, how can we project what it's going to be?

MS. RAY: I think that you raise an excellent point. I projected based on the way our current law pays right now. So I did it based on the profitability of the AWP/

DR. NELSON: Understanding that that may be -- [Indicating.].

MS. RAY: It might, right.

MR. HACKBARTH: It's a significant wild-card in this.

MS. RAY: I think there's also the other issue about broadening the payment bundle. The Commission has gone on record recommending that the Congress instruct CMS to broaden the payment bundle. When the payment bundle is broadened, the separately billable drugs will no longer -- if the broadened payment bundle were to include these separately billable drugs than we would no longer be paying them AWP or on a per-unit basis like we're paying Epo. They would be included in the payment bundle and providers would have the same incentives to efficiently use those services as they do now the composite rate services.

DR. ROWE: Can I comment? I think we're creating a problem for ourselves though a little bit. I know that we have a need to answer all questions that we are asked, particularly those that we are asked by Congress, who we respect greatly. But that does not mean that we have to be illogical. Everyone saw that paying 95 percent of AWP makes no sense at all. I'm not certain but I think my company gets an 80 percent discount off AWP. Something like that. I mean, a huge -- AWP is a made-up number. So everyone has agreed that we're not paying 95 percent of AWP any more, we're paying something else. And this is not only 40 percent of the total billable, or 33 percent of the total billable costs, but it's the largest growing, most rapidly growing piece of the cost.

So we have no idea what that number is going to be. For us to write something, or promulgate something that says that if all these things that we know are going to happen didn't happen, it would be 3 percent less is, I think misleading. We should just not file this, or we should stop this analysis at this point and say, because there's a whale going in the pool here and we don't

know how big the whale is, that we are not able to give meaningful estimates of what the rate will be until we know what this drug is going to cost. I would feel much more comfortable doing that than putting a number up there that we know is going to be wrong.

MR. HACKBARTH: This is a whale potentially. That assumes that something happens in the course of the next year, which I hope is true, but the AWP issue has been a well-known problem for a long period of time.

DR. NELSON: But the proposed rule has been published.

MS. DePARLE: No, the rule that was published was to say that CMS is going to use one carrier as the reference point for AWP. It did not say what the new rates were going to be, I don't think.

DR. MILLER: That's right.

MS. DePARLE: Now the administrator has talked about estimates but --

MR. HACKBARTH: Saying a whale is about to go into the pool, therefore we have no comment on renal services would not be my preferred choice. I think we can say, using the past payment rules, this is where we would be, but a whale is about to go into the pool which means that all of this would be way off the mark.

MS. DePARLE: Can't you do it separately? I thought part of the reason why Nancy was giving us composite rate analysis and the other analysis was to enable us to distinguish somehow --

MR. HACKBARTH: Doing it separately I think gives you such a misleading picture of the industry's financial position.

DR. NEWHOUSE: And we've consistently recommended funding.

MR. HACKBARTH: Right. So this one ought to flash or something, we can have a picture of the whale.

DR. ROWE: We could put the whale on a dialysis machine and we could have a picture.

[Laughter.].

MR. HACKBARTH: We're joking here. Mark is reminding me that we need to be careful in what we say because we don't know how big this mammal is.

DR. ROWE: I think that Mark is expressing what I would interpret is a skeptical view that nothing changes, or it doesn't change much, or it takes a long time, et cetera, and that the pressures on the other side will reduce the amount of reduction, et cetera. But the fact is that this has the potential to be very significant. Notwithstanding the general skepticism about the government in general, I don't know anything specific about this that would lead me to have great confidence that is going to be a small or a big effect. And given that we really shouldn't be promulgating numbers --

MR. HACKBARTH: We need to provide appropriate warnings. Nancy, I'm sorry for the interruption.

MS. RAY: I'd like to talk about several market factors at this point, the first one being the appropriateness of current cost. I've already pointed out to you the spiking of per unit composite rate cost. Again, there's the spiking of per unit cost, and then there's the level, whether or not the data is audited or not audited.

I'd like to now talk about changes in the product. In my review I would say that what I've done is I've looked at several parameters using 1997 data and 2001 data. I would conclude that the product has remained relatively constant. The length of the dialysis session has increased slightly -- and this is CMS numbers -- on average from 210 minutes in 1997 to 215 minutes in 2001. I'm sorry, that was in 2000. The 1997 number was 210 minutes. The 2000 number was 215 minutes on average.

The ratio of technicians to other staff, and the other staff includes -- technicians to all staff, that would include RNs, dieticians, and social workers, has remained steady at 0.54 in both years. Sessions per station also remained steady in 1997 and 2001; on average roughly about 655. The patients to RN ratio has just slightly increased. Again, those are preliminary numbers going from 18 to 19 patients per RN, as well as the patient to technicians numbers. So I think just looking at those five parameters, my assessment is that the product has remained relatively constant.

Now to look at provider entry and exit and changes in the volume of services. I have a couple of graphs to show you. The first is the growth in the capacity to furnish dialysis has steadily increased between 1993 and 2001. On the left-hand side are the number of facilities; on the right-hand side are the total number of dialysis treatments. Treatments have gone up by roughly about 7 percent per year. I did look at what I call same-store growth, the growth in the same facility. I looked at it for 1999 to 2000 and then 2000 to 2001. So the same-store growth increased by 4.7 percent in 2000 to 2001 compared to 4.5 percent between 1999 and 2000.

This graph shows the growth of for-profit facilities. This area seems to be attractive for for-profit facilities. They have increased to roughly 79 percent of all facilities from 61 percent in 1993. Furnishing dialysis services also is attractive to independent providers and I think this demonstrates that facilities can stand on its own, that they don't have to be part of the hospital system. Freestanding facilities increased to 83 percent of all facilities from 70 percent in 1993.

I did look at the characteristics of facilities that closed in 2001. Between 2000 and 2001 there was a net increase of about 156 facilities. Again, that's strictly by looking at the provider ID number. So if a facility just moved across the street that would be counted as a new facility. Facilities that closed were more likely to be small in terms of the number of patients they treated and total hemodialysis stations. They were also more likely to be non-profit and hospital-based compared to those facilities that remained in business in 2001.

Some providers are contending that they are limiting their exposure to Medicare patients. I looked at the percentage of Medicare beneficiaries that were treated and it was roughly the same in facilities that did not operate in 2001 -- roughly 90 percent of patients were Medicare or Medicare entitled, and 91 percent for those that remained in business.

We also looked at quality of care, primarily by using the indicators collected by CMS in their clinical performance measure

project. There was a table in your mailing materials that showed those data. Those showed continued improvements in adequacy of dialysis and anemia management.

Throughout the year we followed the literature and the press about looking at any systematic problems in beneficiaries' access to care and did not find any systematic problems in either 2001 or 2002.

Finally, we looked at access to capital which is necessary for dialysis facilities to improve their equipment and open new facilities, to accommodate the growth in the number of patients requiring dialysis. Again, about 80 percent of the dialysis facilities are for-profit, and the four largest for-profit chains account for about two-thirds of all these facilities. These for-profit chains appear to have adequate access to capital as demonstrated by the growth in the number of clinics, the number of patients they treat, and their earnings.

So based on this evidence staff concluded that current Medicare payments are at least adequate in 2003.

Going to the next step of our framework is estimating increases in providers' costs in the next payment year. We still, unfortunately, don't have CMS's market basket index. That study is still being reviewed within the agency. However, if we do get it between now and the January meeting we will definitely incorporate it into our analysis. MedPAC's market basket for dialysis services actually uses information from price indices for PPS hospitals, SNFs, and home health agencies, and the market basket that we estimate is that providers' costs between 2003 and 2004 will rise 2.7 percent. We will have the most current MedPAC market basket number for you in January.

Other factors affecting providers' costs in the next payment year. Our update framework does consider scientific and technological advances. This factor is designed to include only those new technologies that are quality-enhancing, costly, and have progressed beyond the initial stage of use but are not yet fully diffused into medical practice. Based on staff's review of the literature we believe that the cost of most medical advances will primarily be accounted for through the payments for separately billable drugs.

Finally, as Kevin discussed, MedPAC's update framework reflects the expectation that in the aggregate providers should be able to reduce the quantity of inputs required to produce a unit of service while maintaining service quality. We here also use the 10-year moving average of multi-factor productivity in the economy as a whole, which is 0.9 percent.

Therefore, putting both staff's framework together, our recommendation reflects the increase in the projection to account for providers' costs, the market basket less an adjustment for the growth in multi-factor productivity which is 0.9 percent. So the draft recommendation for you to consider would be that the Congress should update the composite rate by market basket minus 0.9 which is 1.8 percent for calendar year 2004.

Finally, the budget implication. Now this recommendation increases spending. Current law does not provide for an increase in the composite rate payment. It increases spending. The one

year would be the category of $50 to $200 million and our five-year estimate, it would fall into the $250 million to $1 billion estimate.

MR. HACKBARTH: Can I ask you to do one piece of research for January? As I understand it, the rate for Epo is set by statute. Could you look into whether that would be affected by the AWP reform as currently constituted, proposed, since it isn't on the AWP system. There was an effort already to separate from that for this particular drug, and this particular drug is 40 percent of the separately billable, something like that?

DR. ROWE: Maybe more.

MR. HACKBARTH: Maybe more. So that's an important piece of information we need for next time.

MS. RAY: I will go ahead and do that.

DR. ROWE: I want to make a general comment and try to see if the commissioners agree with me on this. First of all, I think this is excellent work. We've become accustomed to Nancy's excellent work. She's widely respected and acknowledged for her expertise in the field, if not feared. In my current work I deal with large dialysis companies regularly, and as some of you know, I was previously a nephrologist earlier in my medical career.

But in reading this material I had a thought that I think we are approaching this wrong. This is going to be a suggestion which has implications for the budget and the workforce of MedPAC so I hesitate, but let me just bring it up. I would accept everything that Nancy wrote and I think it's very well done.

But Congress passed a program to support the management of patients with end-stage renal disease. It's the ESRD program. It's not the dialysis program. I think over time the focus has become the dialysis expense. I think if you look at the total medical expense of patients with end-stage renal disease my bet would be dialysis is well less than 50 percent. These patients are admitted to the hospital very frequently. They have numerous surgical vascular procedures on the fistulas that they have for access. They have a lot of comorbidity. After all, 40 or 50 percent of them have diabetes. That's how they got end-stage renal disease. Or they have longstanding hypertension and they also have other end organ damages, whether it's stroke or heart attack or peripheral vascular disease.

It just seems to me that it would be really helpful for MedPAC to step back and supplement what Nancy does with an analysis of some of the other expenses that are associated, and the trends. We're here to help provide access to high-quality efficient care for all the health care needs of these individuals, not just the dialysis treatments, which is kind of a technical thing.

I'm sure this has been done from time to time but I think it would be really helpful to step back, because sometimes what you make on the peanuts you lose on the potato chips. Sometimes you push more in one are for savings and you wind up saving it, but then you notice that other expenses go up. Like you can reduce pharmaceutical, some state programs reduce the number of prescriptions Medicaid patients could have and they saved money until they saw that hospitalizations rose in that population

because the people ran out of the drugs, so the state actually was spending more money.

I think we need a more holistic, if you will -- an overused term -- view of these patients and what their expenditures are rather than just singular focus on the dialysis treatment. That's just a general suggestion.

MR. HACKBARTH: I think it's along those same lines, I've heard people from the industry propose that there ought to be some component to the payment system that reflects the quality of the service, which may link to whether there are hospital admissions, et cetera. This does seem -- it's true of many chronic diseases. Maybe a little bit more in this case than others, but our focus on paying for individual units of service often seems to miss opportunities for improving care by looking more broadly as to what happens to a patient. So I agree conceptually with what you say.

MR. MULLER: I generally support Jack's suggestion and going back to one of the points I raised earlier, there really aren't that many areas where there's a lot of documentation on how well case management works. Everybody tries to talk about it increasingly. Dialysis is one that there's been some experiments out in the Bay Area that goes on for a number of years. When you see the work that's being done both here and in other countries, just three or four areas, congestive heart failure, diabetes, asthma.

So when you think about the paucity of evidence behind case management in any kind of extensive way, and then the promise that people are trying to hold out for it, I think this is a good area in which to look, in part, as Jack mentioned. I too looked at the cost related to these patients, far less than half, I'd say far less than half are related to the dialysis itself, when you think of all the extensive number of hospitalizations. I seem to remember -- we had a big dialysis program where I used to be and I think on average they would have 14, 15 hospitalizations in the time they were with us in dialysis. They by and large would be five, six years on dialysis and have 14, or 15 hospitalizations. You can do the numbers on that pretty quickly and see how much it overwhelms the cost of dialysis treatment.

So I think both looking at that and thinking more broadly about the kind of evidence we can muster about case management to see -- part by concern is, as we look at broader efforts to manage costs and to not just look at price and volume variations but also see what evidence there is inside the Medicare program of where case management would work, and I think this is certainly one of the three or four prime areas that would be a very fruitful way for us to go.

DR. NEWHOUSE: I'm not clear when Jack raised this, if you had it in mind that this was a June report thing on quality of care. whether you meant this to have implications for --

DR. ROWE: You now know as much about my idea as I do. I wasn't thinking of what chapter or what month.

DR. NEWHOUSE: Okay. I'm trying to square where this is with where the Commission has been. Where we've been on dialysis, or I think we should have been, is to risk adjust and

to bundle. In a sense, Epo going off patent makes it easier to bundle because you don't have to worry as much about the stinting issue, or alternatively, what would you pay for some Epo in addition to the bundled rate?

What I'm wondering is why -- did the Congress hear that and said, no, we don't like that, and that didn't get brought up here because we don't want to keep beating them over the head with it? Or was there no vehicle for it?

MS. RAY: The Congress asked CMS to develop a report on broadening the composite rate bundle. That study was due to the Congress in July of 2002. That study is still being reviewed within the agency. So the Congress did act upon this issue, and hopefully we'll be looking at CMS's study in the near future.

MR. HACKBARTH: So, Joe, you would like to see us make reference to our --

DR. NEWHOUSE: Yes. At least I think rather than just plod ahead with this --

MR. HACKBARTH: Good point.

MS. RAPHAEL: Just for consistency sake, we've looked at the margins for other parts of health care. I was wondering if we knew anything at all about the margins here, given that there's increased consolidation in the industry? There are four large chains that provide the majority of service, I believe, at this point.

MS. RAY: That's a good question. I'll get back to you in January with that. Historically, ProPAC always looked at it, the payment to cost ratio, so that's what I have done. But I can also provide you with margins using the same calculations that the other folks do.

MR. HACKBARTH: Thank you, Nancy.

Next up is ambulatory surgical centers. Next up is ambulatory surgical centers.

MR. WINTER: Good afternoon. I'll be discussing our assessment of payment adequacy for ASC services and our approach to updating payment rates for 2004.

This chart provides some context for considering an update recommendation. It shows the growth in Medicare payments to ASCs from 1991 to 2001 in both nominal and 1991 dollars. In nominal terms, Medicare payments doubled between 1996 and 2001 from about $800 million to $1.6 billion.

Given that CMS plans to soon expand the list of procedures covered in ASCs we anticipate that spending will continue to grow rapidly. In fact ASC payments are projected to grow at an average annual rate of 11 to 12 percent between 2002 and 2007. Currently, payments to ASCs are less than 1 percent of total Medicare spending.

The first question in evaluating payment adequacy is whether the current level of Medicare payments is adequate relative to cost. Because the last survey of ASC costs was conducted in 1994 we have no recent data on costs. Thus, we would look at market factors in judging payment adequacy. These factors include the entry and exit of providers, growth in the volume services, and

access to capital.

As we discussed last month, there has been rapid growth in the number of Medicare certified ASCs. The number of facilities doubled between 1991 and 2001, and increased by 50 percent from 1996 to 2001. Each year from 1997 through 2001 an average of over 270 new ASCs entered the market while about 50 closed or merged with other facilities.

The volume of procedures provided by ASCs to beneficiaries increased by over 60 percent between 1997 and 2001. This increase occurred despite annual updates to ASC rates of less than 1 percent between 1998 and 2002 as mandated by the Balanced Budget Act.

ASCs have strong access to capital, as shown by the growth in the number of facilities and the expansion for-profit ASC chains. Two of the largest ASC chains have received favorable investment ratings over the past year. These firms have been acquiring new facilities and have experienced strong revenue and earnings growth.

These market factors lead us to conclude that Medicare payments to ASCs are more than adequate and that a reduction in the current rate might be warranted.

The next part of the update framework is to ask how much ASC costs will change in the coming, year. The first factor that will affect ASC costs is inflation and input prices. The ASC payment system uses the consumer price index for urban consumers to approximate changes in input prices. The CPI-U is currently projected to increase by 2.7 percent in FY 2004.

ASC costs may also increase due to scientific and technological advances that enhance the quality of care but also raise costs. Unlike the outpatient payment system, there is no pass-through payment mechanism to account for the cost of new technologies., However, the ASC payment system groups many procedures together into large payment categories. This means that the cost of a procedure could increase due to a new technology but still be accommodated by the payment rate for its group.

In addition, it does not appear that the payment system has created barriers to the use of new technologies.

Finally, we are not aware of new breakthrough technologies that would significantly increase ASC costs. Thus, we do not make an allotment for S&TA costs. However, we plan to continue monitoring ASC payments to ensure that they are adequate to cover the cost of new technologies that enhance quality.

The final factor that affects ASC costs is productivity growth. MedPAC has adopted a policy standard for achievable productivity growth equal to 0.9 percent. By subtracting productivity growth from input price inflation, it appears that the cost of ASC services will increase by 1.8 percent in the coming year. We believe that current base payments are at least adequate to cover this increase in cost.

Here's a draft update recommendation for your consideration. For fiscal year 2004, the Congress should eliminate the update to payment rates for ambulatory surgical centers services. Under current law, payments would be updated by the increase in the

CPI-U, which is currently projected to be 2.7 percent. This recommendation is based on our conclusion that current Medicare payments to ASCs are more than adequate cover current costs and at least adequate to cover the increase in next year's costs.

We estimate that this recommendation would reduce spending by a small amount in fiscal year 2004, and by a small amount between FY 2004 and 2008. However, the five-year savings are at the upper end of this small category.

Now I'll move on to discuss a related issue. As we discussed at the last meeting, ASCs receive higher payment rates than outpatient departments for some surgical procedures, including the high volume procedures shown here. This table compares 2003 payment rates in the two settings for these procedures. We can think of no good reason why ASCs should receive higher payments than outpatient departments for the same procedure.

For example, we lack compelling evidence that ASC costs are higher than outpatient department costs. This disparity in payment rates leads to the following draft recommendation. The Congress should ensure that payment rates for ASC procedures do not exceed outpatient hospital rates for those procedures. This refers to the total payment rates, the Medicare portion of the payment plus the beneficiary cost sharing.

This recommendation would help ensure that Medicare does not pay more than necessary for ambulatory surgical procedures. It would also a reduce financial incentives to inappropriately shift services between settings. We estimate that this recommendation would reduce spending by less than $200 million in FY 2004 and by less than $1 billion between 2004 and 2008.

This concludes my presentation. I look forward to any questions you might have been and your discussion.

MS. DePARLE: We had a fairly lengthy discussion of this at the last meeting, but I'm a little bit surprised at the data that you just gave us about the ASC rates because what I remember from the last session was that you provided us with a different table that had in fact some rates, and I thought was something around cataracts but it may not have been, and Bob even commented on how much higher the outpatient department payment was than the ASC. Am I misremembering that?

MR. WINTER: That's right, the table we showed last time was comparing rates for the five highest volume ASC procedures and the number one procedure in terms of volume is cataract removal-lens replacement, which has a higher rate in the outpatient department than the ASC setting.

MS. DePARLE: Substantially higher, as I recall.

MR. WINTER: Actually, that difference has grown smaller over the last couple of years. We were showing you 2001 data last time and we now have 2003 data. I believe the difference is now in the range of about $200 or so.

MS. DePARLE: But it's still higher in the outpatient.

MR. WINTER: Still higher in the outpatient department. This table, I was just focusing on those procedures where the rate is higher in the ASC setting than the outpatient department.

MS. DePARLE: So what this recommendation is that we would

lower all the ASC procedures down to the hospital rates?

MR. WINTER: Yes, that's right, where the ASC rate is higher than the outpatient rate.

MS. DePARLE: I guess I think we should have a discussion of the basis for that kind of -- are we certain that all the hospital outpatient rates are the correct levels for these procedures? I don't know if we are.

MR. HACKBARTH: Let me take a crack at that. Are we certain that the hospital outpatient rates are right? The answer to that would be no. We never are.

DR. REISCHAUER: By right, you mean covering costs.

MR. HACKBARTH: Yes. The question here though is, is there a case to be made for the same service paying more to a freestanding facility than to a hospital outpatient department? I think a case can be made that there is no reason to pay the freestanding more. I'd like to hear what other people think, but my reasoning would be, first of all, the general, if not universal pattern of referral is that more difficult, more challenging, more risk cases are cared for in the hospital outpatient department where back-up is readily available and the like. So there's a systematic process for taking the easier cases to the freestanding facilities, at least in my experience.

So that's point number one. And frankly, I can't remember point number two for the life of me right now. We've been at this for too long.

DR. REISCHAUER: Just go straight to point number three the.

[Laughter.]

MR. HACKBARTH: The second point actually that I was going to make, now that that I've recovered from my lapse of consciousness, is a point that Ralph made at our last meeting. In addition to the patient selection process, through a variety of regulatory standards we impose higher cost on the hospital outpatient department. So through regulation we say they have to have higher cost, and they're taking more difficult patients, but we're going to pay more to a freestanding facility for the same service. To me that's an illogical thing to do.

MS. BURKE: I don't for the moment want to argue on either side of the issue, but I want to understand the follow-up to Nancy-Ann's question. I recall as well a discussion at an earlier meeting where we were shown numbers where the costs for the freestanding were higher? They were lower, correct? There was some that were both.

MR. WINTER: I can clarify this a little bit.

MR. HACKBARTH: They're not costs. They're payments.

MR. WINTER: We weren't comparing cost. We were comparing payment rates. I've looked at all the procedures, types of procedures represented in the latest claims data we have from 2001, and of those procedures there are about 1,000 of them, about 150, or about 12, 13 percent -- actually there are 1,200 procedures and about 150 of those the outpatient rate is lower than the ASC rate, so about 12 to 13 percent if you want just a sense of the total number of procedures, how that works.

MS. DePARLE: So in most cases the hospital payment is higher?

MR. WINTER: That's right.

MS. DePARLE: I think that's what I'm remembering from the last time.

MS. BURKE: You say in both cases. Is it the volume, or is it against the total number of procedures? Is the higher percentage in the actual number of procedures? I'm trying to understand --

DR. NEWHOUSE: It's volume weighted.

MS. BURKE: Is it volume weighted?

MR. WINTER: No, it's not volume weighted. I will go and do that analysis now. That's a good idea. I suspect it's still going to be higher even when you volume weight it. That is, it will be higher in the outpatient department, given that the cataracts --

MS. BURKE: So it will be higher in the outpatient department. So I'm struggling to understand the presumptions here in terms of the freestandings being more costly as is cited here, and your presumption is to bring them down to the hospital. I'm just trying to understand the logic because I'm getting confused as to the earlier conversation and what's being presumed here.

MR. WINTER: We're not suggesting that the ASCs overall receive higher payments than the outpatient departments. We're saying there are certain high-volume procedures where that's the case, and perhaps might be encouraging shifting of services to the ASC setting. We might want to back and revisit whether ASC rates should be higher for any procedure than the outpatient department. But this was drawn to our attention because about seven or eight of the 10 highest volume procedures in the ASC setting, the ASC rate is higher than the outpatient rate.

MR. HACKBARTH: The reason that this has occurred, we have a payment system for ASCs that is an unusual one. The rates are based on very old information which has been inflated by the CPI. That too, I guess, is part of the reason why I feel that it's a reasonable thing to do , to say that we shouldn't pay more than hospital outpatient department. These rates, these high ASC rates for these particular servers are an artifact of a weird system which ought to be changed. We can't change it overnight and this seems to me to be a reasonable short-term step.

DR. WOLTER: Just a couple of observations and questions. One is, are we going to look at the margins in these instances? I think with all the things on the table today and tomorrow, we get a robust look at inpatient margins but we tend not to get presentations on outpatient margins. We've got some very complex discussions coming up on things like IME and transfer rule, and it's very, very hard to come to a judgment on this particular recommendation unless we can see what the margins are in the outpatient hospital arena as well. At least I think it's a relevant question, especially given our conversation this morning, because I would certainly support equalizing and leveling reimbursement across sites. But we should have some information about where the leveling ends up, I think.

DR. REISCHAUER: But this isn't going to affect hospitals at all because we aren't taking hospital outpatient down to ASC.

We're only taking ASC payments that are above the outpatient rates down to what a hospital --

DR. WOLTER: No, I think I was more discussing the recommendation. If I remember, there's a recommendation here not to do an update; is that correct?

MR. WINTER: Yes.

MR. HACKBARTH: But that does not affect the hospital outpatient department. We will take up the update for hospital outpatient department services with the rest of the hospital piece.

DR. WOLTER: Thanks for that clarification. I just think it's an important point because we do have some areas in the course of today where we really are not seeing margin numbers, and yet, as we've said, we want to look at all of these things and try to have some understanding what the impact will be overall.

Then this is also somewhat a controversial area, but the whole area of physician investment, whether it's in ASCs or whether it's in carve-out hospitals or imaging centers, if we are going to proceed in June or perhaps beyond that in looking at issues such as volume of services and quality, I think this is an area that deserves some exploration over time.

MS. ROSENBLATT: I just want to follow up on the question that Sheila was asking because if I'm understanding this correctly, and based on the procedures and what I remember from our previous discussion, you're talking about the 12 percent of the total number of procedures where the ASC is higher than the outpatient. But that 12 percent could represent like 90 or 95 percent of what's done in the ASC. Just looking at the list of procedures it seemed to me that that's the preponderance of what's done there. So the impact on the ASCs is a lot more than one would grasp from saying, it's 12 percent of the procedures. Don't we need to understand what the impact is going to be on a given facility?

MR. WINTER: Yes, that's good point and I will get that number for you for the next meeting. I can't be higher than 70 percent though because the cataract removal procedure accounts for 30 percent of the volume. In that case, the outpatient rate is higher, so it's definitely less than 70 percent.

DR. MILLER: We don't think necessarily that it's even in that ballpark, right?

MR. WINTER: No.

DR. REISCHAUER: What if it were, Alice, and we were paying a whole lot more to create a kind of entity simply because our payments are high?

MS. ROSENBLATT: Do you change it overnight or do you want to transition --

DR. REISCHAUER: No, you might want to let them go out of business gradually without being --

[Laughter.]

MS. ROSENBLATT: That's my point. Let's understand the impact.

MS. DePARLE: I just want to note too, we had a bit of this discussion last, time, but the notion of not having a

differential based on site of service or not creating incentives to do these procedures in one place versus another is something that is a well-tested idea. We did propose in 1998 to redo the payment system because the payment system for ASCs was an early precursor of what we've ended up with on the outpatient side and the notion was it needed to be updated.

One of the reasons why Congress objected quite strenuously to that was because of the lack of data, cost report data, the kind of data that you would want to have to construct some new payment system. In fact Congress has now said that CMS cannot move forward without getting better data. I don't believe they have -- someone was saying they had begun the process. I don't think they have done a survey, have they, Ariel?

MR. WINTER: To our knowledge they haven't. The last official word on this was Tom Scully's letter to Pete Stark in April where he said, we haven't done the survey yet to revise the payment system.

MS. DePARLE: So, Glenn, this may just underscore your point that you can't change a payment system overnight. We're a long way from that, but I think there will be a lot of objections. We're short-circuiting that, is one way to look at it by saying, we'll just equalize everything. Maybe that is just a step toward something that some people would consider a fair payment system, but others might see it as avoiding getting the data that is needed to construct a fairer payment system. I just wanted to make that point.

DR. NEWHOUSE: What if we had a third recommendation on data? It seems innocuous enough.

MR. DURENBERGER: I'm getting to the age where I can't remember what we did at the last meeting but I'm going to try to see if I can capture what we're trying to do here. If I understand the goal -- and if I use the Jack and Ralph rule -- the goal here is to pay for high quality health maintenance for people with, and then you fill in the blank, ESRD, or cataracts, or something like that. The policy statement or the policy process here is the differences -- or the statement of policy we've got to write, differences in payment that are driven by differences in cost of providing the service should not provide financial incentives to shift the site of care or something they like that.

Then there's a statement that says, on our way to defining what kind of payment system will provide that incentive, we recommend, whatever that recommendation was up there. I'm struggling for a context in which to do the cap so people know where we're going.

MR. HACKBARTH: I think you've said it well. There's a long-term issue of reforming our payment system for services that are provided in multiple sites. For example, ASCs, hospital outpatient departments, and in some cases, physician offices. Those are interconnected issues, although in the past sometimes we've treated them like they're totally independent. So that's a major area for potential reform, but that's not going to happen quickly. In fact I think as you delve into it it's actually a fairly complicated issue, even from a conceptual level, let alone

an operational level. So that's point number one.

Even given all that, having rates that are higher for freestanding facilities than hospital outpatient departments seems to me to be anomalous, given the patient selection issues, the regulatory issues, and the like. So we could say, we're not going to do anything until we've got the long-term reform in place. But what that means is allowing to persist, the movement of services from hospital outpatient departments to freestanding facilities at a higher cost to the Medicare program for at least some services with an adverse effect on the hospitals' financial performance and viability with no gain to the Medicare beneficiaries in terms of quality, although admittedly it may be a gain in terms of service and ease of use and the like.

MR. DURENBERGER: I just want not to leave this -- if this is the stated policy goal, it has significance beyond just ASCs. If we think it's good payment policy for Medicare, that differences that are driven by differences in cost -- should not provide financial incentives to shift the site of care, or something like that. That means that if you actually want to pay more to put them in another setting, the money ought to come from someplace other than Medicare, conceivably. I'm searching for the policy here, which is that now on our goal should be that Medicare pays for a high quality health maintenance for people with ESRD, or cataract surgery or something like that --

DR. REISCHAUER: The appropriate site, because differences in patient's conditions, et cetera, might require a more high-cost --

MR. DURENBERGER: Absolutely, for that particular patient in that particular condition.

MR. HACKBARTH: Whether you want the policy to be we pay the lowest rate consistent with high quality service, or equal rates, or equal margins on the different locations, there are a lot of different ways that you could cut this. I frankly don't know which is the right one.

If you want true neutrality, maybe the margin is what matters. You don't make more money in one location or the other so financial considerations are irrelevant. I don't know.

What I would ask is that we try not -- we avoid trying to answer this very, big complicated question right now and focus on the immediate issue of what we do in this situation where we pay more for ASCs than for hospital outpatient departments.

MR. WINTER: If I could just add something about the impact of this recommendation. We did a simulation of what the impact would be on total ASC payments using 2001 volume and we found that it would reduce payments by about 7 percent. So that gives you some idea of what the impact would be.

DR. MILLER: Just to clarify you said, you said 7 percent?

MR. WINTER: Yes.

DR. MILLER: Then there's just one other comment in terms of concern about the impact on the industry. Ariel said it but I think it's worth repeating, the growth in the number of ASCs is phenomenal right now, which would suggest that there is enough money on the street to pay for these services.

MR. MULLER: My question or comment is along those lines.

We've now had a number programs we discussed today where there has been, it seems to me, some considerable growth in for-profit facilities. Have we ever taken the growth of the for-profit sector as any indicator of payment adequacy in our considerations? The spirit in which the for-profits are growing, do we take that as a marker of payment adequacy, have we?

MR. HACKBARTH: Growth in general we have used as a marker, and often it's for-profit facilities, but we don't usually break it down.

DR. NEWHOUSE: We often do break it down. I would have said where for-profit facilities are a relevant actor, they're more of a leading indicator because they're quicker to enter and to exit in response to incentives. But we have never really singled out their margins versus non-profit margins, I think.

MR. HACKBARTH: I would agree with that, Joe.

DR. NEWHOUSE: I was quite going to underscore what Mark said, that we're certainly inferring that the margins are robust given the entry behavior here. That should govern, I think, our attitude toward the overall update factor, that plus some -- if we think they're too robust, we're still trying to make some kind of transition so market basket, or no update seems fine as a transition strategy to me. Then I assume we're talking about the OPD, the recommendation two of the OPD ceiling on top of that, which is also fine with me given that I think probably the overall size of the pot here is more than adequate.

DR. REISCHAUER: I have a question for you, Ariel. There's going to be an expansion in the number of procedures that ASCs will be allowed to do in 2003? How are those going to be priced?

MR. WINTER: That's a very good question. We're all eagerly anticipating that Federal Register notice which will tell us how they're going to price the new procedures they're adding to the list.

DR. REISCHAUER: But presumably once they're priced then they will be under the ASC system and will, until the system is reformed, rise with CPI even if they're subject to declining costs because they're new kinds of procedures, in which case our second recommendation could become more important over time.

DR. NEWHOUSE: Are these differentially things that are now in the office?

DR. REISCHAUER: No, these are things that are in outpatient.

DR. NEWHOUSE: I thought we were talking about relaxing the 50 percent office rule, too.

MR. WINTER: That was the '98 proposal. We're not sure if they're going to finalize that or go back to the current standards. We really don't know until --

DR. NEWHOUSE: Because I could see an analogous thing coming on the office side, if we have a lot of things that are now office-based moving toward ASCs, which wouldn't seem to be that hard in areas where there's ASCs.

DR. REISCHAUER: In which case we might want to next year revisit this and say, you can't pay more than the office charge.

DR. NEWHOUSE: I'm wondering if we should foreshadow some of that now, if this is the direction it's -- your question is a

very good one on what the new procedures are. It's the whale two.

MR. MULLER: A lot of the growth in fact is turning the office-based ones into ASCs. That's what's happening.

DR. NEWHOUSE: That's what I thought.

DR. NELSON: There's just all whole host of those procedures that can't done, arguably cannot be done safely in the office.

DR. NEWHOUSE: I'm talking about stuff that is now done in the office.

DR. NELSON: They may be in some cases, but you can argue that they can't be done as safely.

DR. NEWHOUSE: They're being done in the office now but it's not safe?

DR. NELSON: I am saying that one could argue, as some gastroenterologists have argued, that the outpatient colonoscopy can be done in the office but there's a higher margin of safety if it's done in an OPD.

MR. HACKBARTH: We have some research questions for you and we'll take this up again in January. I don't know about anybody else but I'm wearing out here.